Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Hospital for Specialized Surgery

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-0155-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the attached Surgery Scheduling Forms…. Dr. Mark Henry deemed the patient's condition a **MEDICAL EMERGENCY** and with a time sensitivity of **WITHOUT DELAY**. Therefore no authorization is required for the services…"

Amount in Dispute: $33,990.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…This second surgery on 3/1/13 was planned in advance. And because of this Texas Mutual argues it could not possibly be an emergency as defined by Rule 133.2. No payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2013	Outpatient Hospital Services	$33,990.40	$6,167.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - 193 – Original payment decision is being maintained

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. What is the applicable rule for determining reimbursement for the disputed services?

3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 197 - "Precertification/authorization/notification absent."

   Review of the submitted "Operative Report" finds the following; "Both wounds presented contaminated and required initial debridement, open wound care, and antibiotic period previously in order to make them clean enough for reconstruction…" The Division finds the submitted documentation supports this procedure meets the definition of Rule 133.2, "placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part;" and therefore, these disputed services will reviewed in accordance with applicable fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2175 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code Q0172 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 15004 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0134, which, per OPPS Addendum A, has a payment rate of $251.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $150.89. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $149.68. The non-labor related portion is 40% of the APC rate or $100.59. The sum of the labor and non-labor related amounts is $250.27. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $125.14. This amount multiplied by 200% yields a MAR of $250.28.
   - Procedure code 15240 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0136, which, per OPPS Addendum A, has a payment rate of $1,111.61. This amount multiplied by 60% yields an unadjusted labor-related amount of $666.97. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $661.63. The non-labor related portion is 40% of the APC rate or $444.64. The sum of the labor and non-labor related amounts is $1,106.27. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the

total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.207. This ratio multiplied by the billed charge of $10,214.00 yields a cost of $2,114.30. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $553.14 divided by the sum of all APC payments is 29.77%. The sum of all packaged costs is $1,024.72. The allocated portion of packaged costs is $305.06. This amount added to the service cost yields a total cost of $2,419.36. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,451.36. 50% of this amount is $725.68. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $1,278.82. This amount multiplied by 200% yields a MAR of $2,557.64.

- Procedure code 26952 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0053, which, per OPPS Addendum A, has a payment rate of $1,185.44. This amount multiplied by 60% yields an unadjusted labor-related amount of $711.26. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $705.57. The non-labor related portion is 40% of the APC rate or $474.18. The sum of the labor and non-labor related amounts is $1,179.75. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.207. This ratio multiplied by the billed charge of $11,662.00 yields a cost of $2,414.03. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,179.75 divided by the sum of all APC payments is 63.49%. The sum of all packaged costs is $1,024.72. The allocated portion of packaged costs is $650.64. This amount added to the service cost yields a total cost of $3,064.67. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,000.11. 50% of this amount is $500.06. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,679.81. This amount multiplied by 200% yields a MAR of $3,359.61.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $6,167.53. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $6,167.53. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,167.53.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,167.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July10, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.